

***United States Court of Appeals
for the Second Circuit***



**APPELLANT'S
BRIEF**

77-6174

ORIGINAL

IN THE
United States Court of Appeals
FOR THE SECOND CIRCUIT

HOSPITAL ASSOCIATION OF NEW YORK STATE, INC., MISERICORDIA
HOSPITAL MEDICAL CENTER, BUFFALO GENERAL HOSPITAL, THE
GENESEE HOSPITAL, and THE MOUNT SINAI HOSPITAL on
behalf of themselves and all other nonprofit hospitals
which are members of the HOSPITAL ASSOCIATION OF NEW
YORK STATE, INC., and which are reimbursed for Medic-
aid Services rendered to hospital patients,

Plaintiffs-Appellants,

—v.—

PHILIP L. TOIA, as Commissioner of Social Services of the
State of New York, ROBERT P. WHALEN, as Commissioner
of Health of the State of New York, PETER GOLDMARK,
as Director of the Budget of the State of New York,
HUGH L. CAREY, as Governor of the State of New York,

Defendants-Appellees,

—and—

F. DAVID MATHEWS, as Secretary of the United States
Department of Health, Education and Welfare,

Defendant.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK

BRIEF FOR PLAINTIFFS-APPELLANTS

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TABLE OF CONTENTS

	<u>Page</u>
TABLE OF AUTHORITIES.....	(i)
STATEMENT OF THE ISSUE.....	1
STATEMENT OF THE CASE.....	2
STATEMENT OF FACTS.....	4
Medicaid Reimbursement.....	4
Reimbursement Under the New York State Plan.....	5
The 1976 Amendments to the State Plan.....	8
A. 10 NYCRR §86-1.14(b).....	9
B. 10 NYCRR §86-1.13(c).....	11
C. 10 NYCRR §86-1.26.....	12
D. 10 NYCRR §86-1.21(k).....	13
E. 10 NYCRR §86-1.31.....	16
F. 10 NYCRR §86-1.15(b).....	17
G. 10 NYCRR §86-1.8(i).....	18
H. 10 NYCRR §86-1.21(i).....	19
I. Appeals.....	20
1. In General.....	20
2. 10 NYCRR §86-1.17.....	21
J. The Out-Patient Freeze.....	23
K. The Base Year For 1978.....	24
This Appeal.....	24

	<u>Page</u>
SUMMARY OF ARGUMENT.....	26
ARGUMENT:	
I. THERE REMAINS A LIVE CONTROVERSY BETWEEN THE PARTIES REGARDING THE STATE PLAN WHICH SHOULD BE ADJUDICATED BY THE DISTRICT COURT.....	27
II. THE STATE DEFENDANTS' ACTIONS ARE CAPABLE OF REPETITION AND, HENCE, APPROPRIATE FOR ADJUDI- CATION WHATEVER THE EFFECT OF THE 1977 AMENDMENTS.....	37
III. THE ELEVENTH AMENDMENT ONLY BARS THE AWARD OF COMPENSATORY PAYMENTS FOR ACCRUED MONETARY LIABILITY.....	42
CONCLUSION.....	51

TABLE OF AUTHORITIES

	<u>Page</u>
<u>CASES:</u>	
<u>Alabama Nursing Home Ass'n. v. Califano,</u> 433 F. Supp. 1325 (M.D. Ala. 1977).....	50n.
<u>Big Rivers Electric Corp. v. E.P.A.,</u> 523 F.2d 16 (6th Cir. 1975), <u>cert. denied,</u> 425 U.S. 934 (1976).....	38-39
<u>Browning Debenture Holders Committee v.</u> <u>DASA Corp.,</u> 524 F.2d 811 (2d Cir. 1975).....	37
<u>Class v. Norton,</u> 505 F.2d 123 (2d Cir. 1974).....	45n.
<u>DeFunis v. Odegaard,</u> 416 U.S. 312 (1974).....	37
<u>Edelman v. Jordan,</u> 415 U.S. 651 (1974).....	42-49, 49n.
<u>General Electric Co. v. Local 761,</u> 305 F.2d 891 (6th Cir. 1968).....	49n.
<u>Golden Holiday Tours v. C.A.B.,</u> 531 F.2d 624 (D.C. Cir. 1976).....	39-40
<u>Jordan v. Trainor,</u> 551 F.2d 152 (7th Cir. 1977), <u>rehearing en banc granted</u> (April 25, 1977).....	46-49, 49n.
<u>Kaye v. Funding Systems Corp.,</u> No. 76-7272 (2d Cir. June 20, 1977).....	32-33, 37-38, 40
<u>Lewis v. Shulimson,</u> 534 F.2d 794 (8th Cir. 1976), <u>cert. denied sub nom. Gourley v. Lewis,</u> 97 S. Ct. 1570, <u>rehearing denied,</u> 97 S. Ct. 2643 (1977).....	50
<u>Local No. 2 v. Paramount Plastering, Inc.,</u> 310 F.2d 179 (9th Cir. 1962).....	48n.
<u>Local 74 v. N.L.R.B.,</u> 314 U.S. 707 (1951).....	37
<u>Milliken v. Bradley,</u> 97 S. Ct. 2749 (1977).....	44, 47
<u>National Association of Greeting Card</u> <u>Publishers v. United States Postal Service,</u> No. 75-1856 (D.C. Cir. December 28, 1976).....	34, 38

	<u>Page</u>
<u>National Foundation v. City of Fort Worth</u> , 415 F.2d 41 (5th Cir. 1969), <u>cert. denied</u> , 396 U.S. 1040 (1970).....	34-35, 38
<u>Natural Resources Defense Council, Inc. v.</u> <u>E.P.A.</u> , 489 F.2d 390 (5th Cir. 1974) <u>reversed on other grounds</u> , 421 U.S. 60 (1975).....	35
<u>Oklahoma v. Civil Service Commission</u> , 330 U.S. 127, 143 (1947).....	50n.
<u>Ove Gustavsson Contracting Co. v. Floete</u> , 278 F.2d 912 (2d Cir. 1960).....	49n.
<u>Public Service Commission v. Wycoff Co.,</u> <u>Inc.</u> , 344 U.S. 237 (1952).....	48n.
<u>Rodriguez v. Swank</u> , 496 F.2d 1110 (7th Cir.), <u>cert. denied</u> , 419 U.S. 885 (1974).....	45n.
<u>Roe v. Wade</u> , 410 U.S. 113, 125 (1973).....	37
<u>Rothstein v. Wyman</u> , 467 F.2d 226 (2d Cir. 1972), <u>cert. denied</u> , 411 U.S. 921, <u>rehearing denied</u> , 411 U.S. 988 (1973).....	46, 47
<u>Shank v. N.L.R.B.</u> , 260 F.2d 444 (7th Cir. 1958).....	49n.
<u>Steward Machine Co. v. Davis</u> , 301 U.S. 548 (1937).....	50n.
<u>United Airlines, Inc. v. C.A.B.</u> , 518 F.2d 256 (7th Cir. 1975).....	38, 39
<u>United States v. W.T. Grant Co.</u> , 345 U.S. 629, 633 (1953).....	40
 <u>CONSTITUTIONAL PROVISIONS:</u>	
Eleventh Amendment to the United States Constitution.....	passim

	<u>Page</u>
<u>STATUTES AND REGULATIONS:</u>	
42 U.S.C. §1396 (a)(13)(D).....	5n., 21
45 C.F.R. §250.30(a)(2)(ii).....	5n.
Chapter 76 of the Laws of 1976.....	23
Chapter 77 of the Laws of 1977.....	23, 31n.
New York State Plan for Medical Assistance.....	passim
10 NYCRR §86-1.8(f).....	16
10 NYCRR §86-1.8(i).....	15, 18-19, 20
10 NYCRR §86-1.11.....	24, 31
10 NYCRR §86-1.13.....	7n.
10 NYCRR §86-1.13(c).....	11-12, 30
10 NYCRR §86-1.14(b).....	9-10, 29
10 NYCRR §86-1.15.....	24, 31
10 NYCRR §86-1.15(b).....	17
10 NYCRR §86-1.17.....	21-23
10 NYCRR §86-1.21(i).....	19-20
10 NYCRR §86-1.21(k).....	13-15, 30, 31
10 NYCRR §86-1.26	12-13
10 NYCRR §86-1.31.....	16-17
Transmittal 77-7.....	8n.
Department of Health Hospital Memorandum 76-132 (December 15, 1976).....	22n.

	<u>Page</u>
<u>CONGRESSIONAL MATERIALS:</u>	
Pub. L. No. 94-552, 94th Cong., 2d Sess. (1976).....	24
S. Rep. No. 1230, 92nd Cong., 2d Sess. 325 (1972).....	22

UNITED STATES COURT OF APPEALS
FOR THE SECOND CIRCUIT

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HOSPITAL ASSOCIATION OF NEW YORK STATE, :
INC., MISERICORDIA HOSPITAL MEDICAL :
CENTER, BUFFALO GENERAL HOSPITAL, :
THE GENESEE HOSPITAL, and THE MOUNT :
SINAI HOSPITAL on behalf of themselves :
and all other nonprofit hospitals which :
are members of the HOSPITAL ASSOCIATION :
OF NEW YORK STATE, INC., and which are : Docket No.
reimbursed for Medicaid Services : 77-6174
rendered to hospital patients, :
:

Plaintiffs-Appellants, :

-against- :

PHILIP L. TOIA, as Commissioner of :
Social Services of the State of New :
York, ROBERT P. WHALEN, as Commissioner :
of Health of the State of New York, :
PETER GOLDMARK, as Director of the :
Budget of the State of New York, HUGH :
J. CAREY, as Governor of the State of :
New York, :

Defendants-Appellees, :

-and- :

DAVID MATHEWS, as Secretary of the :
U.S. Department of Health, Education & :
Welfare, :

Defendant. :

-----x
ON APPEAL FROM THE UNITED STATES DISTRICT
COURT FOR THE SOUTHERN DISTRICT OF NEW YORK

BRIEF FOR PLAINTIFFS-APPELLANTS

STATEMENT OF THE ISSUE

Whether the District Court's vacatur on Eleventh
Amendment grounds of the August 2, 1976 judgment against the

State defendants insofar as it granted monetary relief, and the amendments to the New York State Plan for Medical Assistance made by the State defendants for 1977, have mooted the case.

STATEMENT OF THE CASE

This appeal has been consolidated with Docket No. 77-6152. Plaintiffs-appellants accordingly incorporate by reference the "Statement of the Case" contained in their brief in that appeal with the following supplementation:

The hospitals of New York State, when they filed the original complaint in this action in May, 1976, sought nothing more than to preserve a reasonable level of Medicaid reimbursement, as prescribed by the Medicaid Act. But the history of this case has seen a series of procedural obstacles thrown up to keep the hospitals from having their day in court.

When this action was commenced, the State had waived its immunity to suit in the federal courts, pursuant to a provision of the Medicaid Act, and a judgment for money was granted to the hospitals on August 2, 1976 (428).^{*} The Court below found that the State defendants had acted "in blatant disregard" of federal law. (713). Then, after Congress amended the waiver provision of the Medicaid Act, the State

^{*} Unless otherwise indicated, parenthetical references are to the Joint Appendix.

withdrew its waiver of immunity, purporting to make the withdrawal retroactive so as to nullify the District Court's judgment. The District Court then vacated its judgment. (763)

During that time, the State defendants made certain changes in the State Plan as applied in 1976. They then claimed that, between the retraction of their waiver and their amendments to the State Plan, they had managed to make this case moot. The motion was granted by the District Court and plaintiffs appeal from the judgment of dismissal, entered October 18, 1977 (888,891).

Unless the judgment of dismissal is reversed, the hospitals of New York State will never be able to vindicate their federal rights in a federal forum. Since the commencement of this lawsuit, the State Plan has been amended at least twice. If every amendment to the State Plan moots any pending lawsuit challenging any part of that Plan, State officials can, by administrative fiat, preclude federal judicial oversight of the operation of a federally-funded program.

The 1976 amendments to the State Plan most damaging to the hospitals, which are being challenged in this lawsuit, remain in force. As more fully explained, infra, the 1977 amendments did not ameliorate the deleterious effects of the 1976 amendments complained of by plaintiffs. The general rate-making concept and methodology introduced in 1976 continues to govern the administration of the State Plan.

Although the State defendants have argued that the impact of the 1977 amendments has been substantial and, accordingly, has mooted this case, they have utterly failed to satisfy the requisite standard of proof on this question. Moreover, these defendants, who have acted in "blatant disregard" of federal law (713), have offered no assurances that their objectionable practices will not be repeated.

This Court should therefore reverse the judgment below and remand for a trial on the merits in order to allow plaintiffs to establish their rights and to compel defendants to conform their conduct to standards essential to the integrity of this federal social welfare program.

STATEMENT OF FACTS

Plaintiffs incorporate by reference the "Statement of Facts" in their brief in Docket No. 77-6152 (at pp. 6-16), with the following supplementation:

Medicaid Reimbursement

With respect to reimbursement for in-patient hospital care the Medicaid Act permits two different approaches. A State may either calculate its reimbursement according to the principles enunciated in the Medicare Act and regulations, or it may develop a so-called "alternative methodology" -- one other than the Medicare system. While the Medicaid Act and

regulations* do not spell out in detail the requirements for an alternative methodology, they do set forth a number of general prerequisites to approval:**

First, an alternative methodology must reimburse hospitals for the reasonable costs they incur in providing in-patient hospital care;

Second, an alternative methodology must give "[a]ssurance of adequate participation of hospitals and availability of hospitals [sic] services of high quality to title XIX [i.e., Medicaid] recipients"; and

Third, an alternative methodology must provide incentives for efficiency and economy of hospital operations.

Reimbursement Under the New York State Plan

During its first four years of operation in New York State, Medicaid reimbursed hospitals for the in-patient care they provided on a retrospective basis, as does Medicare. That is, the amount of reimbursement to be paid was calculated after services were provided and was based on actual costs incurred. In 1970, however, the State changed the method by which reimbursement was calculated, adopting a prospective

* The Medicaid regulations are found in Volume 45 of the Code of Federal Regulations.

** These prerequisites are found in 42 U.S.C. §1396a(a)(13)(D) and 45 C.F.R. §250.30(a)(2)(ii).

system. This prospective reimbursement methodology is a type of "alternative methodology", discussed above.

Under a prospective system, rates are announced before services are provided and are based on past costs projected forward to the reimbursement year. In theory, if a hospital knows how much it will be paid long enough before care is rendered, it will be able to plan its expenditures.

Reimbursement for in-patient hospital care under the New York State Plan is made on a per diem basis. That is, a hospital is paid an unvarying dollar rate for each day of care rendered to a Medicaid patient regardless of the type of services provided.

While the details of the calculation of the in-patient rates are complicated, the following is a general explanation of the methodology applied prior to the 1976 amendments at issue:

First, a determination was made of a hospital's allowable costs incurred in the "base year", which was the second year preceding the rate year. Allowable costs fell into a number of categories, including the following: (1) routine costs (e.g., the costs of housing, food, administrative expenses and routine nursing, as well as costs asso-

ciated with intensive nursing care units); (2) ancillary costs (e.g., the costs of the departments directly diagnosing and treating patients, such as radiology departments, laboratories and operating rooms); (3) costs related to interns and residents; (4) real property costs; and (5) costs of schools of nursing.

Second, a hospital's routine costs were segregated from all other allowable costs, totalled and divided by the number of a hospital's base year patient days.* The result was the hospital's base year routine per diem cost.

Third, hospitals were grouped according to certain common characteristics, i.e., size, type of hospital (teaching or non-teaching), geographical area for non-teaching hospitals, and sponsor (voluntary, public or proprietary).** A weighted average was then calculated of the routine per diem costs for the hospitals in each group. To the extent that a hospital's routine per diem costs exceeded 110% of the weighted average per diem routine cost for the hospital's group, the costs were disallowed, although this disallowance was appealable. The amount per diem disallowed was then multiplied by the hospital's base year patient days and subtracted from the hospital's allowable costs.

* Base year patient days were calculated by aggregating the number of days of care given each in-patient in the base year.

** That part of the State Plan relating to in-patient reimbursement is codified in 10 NYCRR Part 86. But see page 8n., infra. The grouping criteria are found in 10 NYCRR §86-1.13.

The remaining routine costs, plus the other allowable costs (except for real property), were then brought forward from the base year to the rate year by adjusting for anticipated increases in costs due to inflation.* This adjusted total, with the unadjusted real property costs added back in, was divided by the number of base year patient days of care to arrive at the final per diem rate paid in the rate year.**

The 1976 Amendments to the State Plan

As more fully explained in plaintiffs' brief in Docket No. 77-6152 (pp. 7-8), in 1976 the State defendants attempted to revise the State Plan to bring Medicaid expenditures within predetermined budgetary limits, irrespective of whether the resulting reimbursement rates would be reasonably related to the hospitals' costs. HEW regarded the amendments as significant enough to cause it to review the Plan as if it were a new methodology.

The Secretary approved those amendments in August and October, 1976. Since that time, further amendments have been approved for 1977.*** The 1977 amendments did not, however,

* This was accomplished by multiplying the remaining allowable base year costs by the so-called trend factor. See p. 14, infra.

** Hospitals whose occupancy rates were below the minimum utilization standards set by the State could be penalized by having their final per diem rates reduced.

***Transmittal 77-7 (revised) (approved May 1, 1977). This is the latest revision in the State Plan applicable to Medicaid; provisions appearing in 10 NYCRR Part 86 that are different from Transmittal 77-7 are only applicable to Blue Cross rates.

change most of the features introduced into the State Plan by the 1976 amendments, which are the subject of this litigation. Thus, the following elements of these 1976 amendments continue to affect the calculation of reimbursement under the State Plan:

A. 10 NYCRR §86-1.14(b).

Under the State Plan in effect prior to the 1976 amendments, a ceiling was applied to the reimbursement of a hospital's in-patient routine costs, as explained above.

Section 86-1.14(b) of the 1976 amendments effected a major change in the limitation applied to the base year routine costs that were projected forward. The ceiling on per diem routine costs was lowered from 110% to 100% of the weighted group average. In effect, all allowances for differences among hospitals that caused per diem routine costs to exceed the group average were eliminated.

The arbitrary inflexibility of the ceiling is compounded by the fact that if hospitals reduce their costs to meet the 100% ceiling, later years' 100% ceilings will be even lower (since the reduction brings down the group average). The 100% ceiling thereby irrationally compels a constant increase in hospital deficits.

Furthermore, since hospitals, by their nature, are not identical, some hospitals will be above the 100% ceiling

even if all hospitals are operating at peak efficiency. Thus those hospitals whose costs are above the group average will be penalized to that extent, regardless of the efficiency of their operation.

In addition, Section 86-1.14(b) imposed, for the first time, a ceiling on the reimbursement of ancillary costs. By a formula similar to that used for routine costs, the weighted average of the ancillary costs per discharge incurred by hospitals in each group was calculated and all ancillary costs in excess of 100% of the weighted group average were disallowed. Thus, not only were all allowances for differences among hospitals that caused variations in routine costs eliminated, but all allowances for differences among hospitals that caused variations in ancillary costs were eliminated as well.

The 1977 amendment to section 86-1.14(b) added a provision imposing yet another ceiling, this one on routine costs based on the excess of a hospital's average length of stay over the weighted average length of stay of a hospital's group, the disallowance not to exceed the equivalent of two days. No change was made, however, in the 100% ceilings originally added in 1976 which are challenged in this action.

E. 10 NYCRR §86-1.13(c).

As just explained, under the State Plan as amended in 1976 the per diem routine cost ceiling was reduced from 110% to 100% of the weighted group average. The reduction in the ceiling is actually greater than 10% for many hospital groups, however, because the calculation of the weighted group average is distorted by the application of section 86-1.13(c), also added to the State Plan in 1976.

Specifically, under section 86-1.13(c), after the weighted group average routine per diem cost is calculated, all hospitals whose per diem routine costs exceed 125% of the weighted group average or are less than 75% of the weighted group average, as then calculated, are set to one side. A second weighted group average is then calculated, using the costs of the remaining hospitals, and this second weighted group average becomes the per diem routine cost 100% ceiling. An identical calculation is applied to the computation of the 100% ancillary cost ceiling.

The under-reimbursement caused by the 100% ceiling enacted in 1976 is thus aggravated by section 86-1.13(c), because, by excluding from the calculation of the final group average all hospitals whose costs exceed 125% of the preliminary group average, the actual ceilings often fall well below 100% of the group average. Thus, many hospitals are

not really expected to conform their costs to the costs of the hypothetical average hospital in their group, but rather to some figure below the average.

The 1977 amendments made no change in the arbitrary 75%-125% exclusion.

C. 10 NYCRR §86-1.26

Section 86-1.26 relates to reimbursement for the salaries and fringe benefits of interns and residents. This provision excludes from allowable costs a portion of the salary and fringe benefit costs attributable to interns and residents "properly chargeable to educational activities not directly related to patient services." In fact, the State has imposed an automatic 10% disallowance under this provision, which is not even appealable.

The basic fallacy of section 86-1.26 is that it raises an irrebutable presumption that interns and residents are being paid to learn rather than to treat patients.

However, section 86-1.26 ignores the facts that interns and residents: (1) traditionally work at least 50 to 60 hours per week; (2) provide vitally needed patient services; (3) are paid far less than the hospitals would have to pay fully-licensed physicians to provide the same services; and (4) provide their services for lower pay in part consideration for their education.

Moreover, under section 86-1.26 it is impossible for a hospital to economize and avoid the disallowance. Assume, for example, that a hospital spends \$1,000,000 in a base year for interns and residents. A portion of that expenditure, \$100,000, will be disallowed when calculating costs to be trended forward to the rate year. However, even if the hospital reduces its staff of interns and residents in the rate year to respond to the disallowance and the resulting \$900,000 limit, it will still be subject to a further disallowance on the money it spends in the rate year on interns and residents. This is because any sums spent in the rate year will be subject to the same disallowance when those rate year costs become base year costs for later rate years. In short, it is impossible for a hospital to avoid the disallowance unless it eliminates its interns and residents entirely and replaces them with more expensive fully-licensed physicians.

The 1977 amendments made no change in this provision.

D. 10 NYCRR §86-1.21(k).

Section 86-1.21(k) imposed a new limitation on the amount of the base year costs that can be used to establish reimbursement rates. Pursuant to this provision, the increase in allowable costs from the year before the base year

("the prior year") to the base year is calculated. Cost increases are disallowed insofar as they exceed the Health Department's trend factor from the prior year to the base year.

The trend factor is used to project inflationary increases between the base year and the rate year. It is actually made up of two components. The first is meant to represent the rate of inflation from the base year to the so-called intermediate year, and the second, the rate of inflation from the intermediate year to the rate year. Thus, when section 86-1.21(k) is applied to rate calculations for the first time in 1978, it will require the Health Department to limit actual cost increases from 1975 to 1976 (the latter being the base year for 1978) to the 1975-1976 component of the trend factor.

Section 86-1.21(k) accentuates the inequities caused by the ceiling provisions and other 1976 amendments for the following reasons:

First, due to the disallowance of all cost increases between the prior year and the base year that exceed the estimated inflation rate for that period, hospitals will necessarily be under-reimbursed in the rate year if the estimated rate is too low. The Health Department has a history of underestimating the inflation rate, and thus it is probable that there will be miscalculations prejudicial

to the hospitals. Despite the likelihood of error, there is no regulation that requires the Commissioner to adjust retroactively the estimated inflation rate to conform to the actual inflation rate.

Second, the distortion caused by a miscalculation in the inflation rate is compounded in future years. This is because the base year costs in one year become the prior year costs for a later year. If the base year costs are artificially reduced by the application of section 86-1.21(k), they will still be artificially reduced when they are used as prior year costs. Thus, the application of the inflation factor to these artificially reduced prior year costs will necessarily result in a lower level of base year costs in subsequent years. For example, 1976 is the base year for 1978 and will be the prior year when 1979 rates are calculated. Therefore, the artificial reduction of 1976 costs will affect the calculation of rates for 1978, 1979 and subsequent years.

Third, further distortions are caused by the admitted fact that the inflation factor does not take into account increases in costs caused by expansion of facilities, changes in technology, increased intensity of service or changes in patient mix, although the methodology reduces reimbursement when any of these factors reduces costs.

Finally, like the ceiling provisions, section 86-1.21(k) makes no allowance for natural differences among hospitals.

The 1977 amendments made no change in this provision.

E. 10 NYCRR §86-1.31.

Section 86-1.31, also added in 1976, requires a hospital to notify the Health Department of the deletion of any previously offered services or the withholding of any services from government-sponsored patients. Section 86-1.31 also states that "[a]ny over-payments by reason of such deletion of previously offered service shall bear interest and be subject to penalties" as set forth in section 86-1.8(i).*

When combined with the other 1976 amendments, section 86-1.31 has an invidious effect on reimbursement. The under-reimbursement caused by the ceilings requires hospitals to eliminate services in order to survive. However, as the services are eliminated, the Health Department further reduces the reimbursement rate. The cycle is constant and unending.

Moreover, like so many of the other amendments, section 86-1.31 nowhere defines its terms. Thus, for example, a hospital has no way of knowing what constitutes a deletion of services within the meaning of the provision.

* Section 86-1.31, in fact, mistakenly refers to subsection (f), which embodied this provision before the regulation was re-lettered as subsection (i) in 1977.

Finally, section 86-1.31 does not grant a hearing to hospitals or any other adequate opportunity to contest a determination that an overpayment has been made and that interest and penalties should be imposed.

The 1977 amendments made no change in this provision.

F. 10 NYCRR §86-1.15(b)

Section 86-1.15(b) excludes from the allowable costs that are trended forward to allow for inflation leases of equipment and depreciation and interest related to equipment. In other words, by the terms of section 86-1.15(b), any increase in hospital costs from the base year to the rate year attributable to inflationary increases in these costs is not recognized.

In view of the facts that: (1) equipment is subject to rapid technological obsolescence; (2) there are annual changes in equipment needs; (3) the amounts charged by equipment lessors are subject to the same inflationary pressures as other costs; and (4) equipment leases are usually short-term in nature, it makes no sense to exclude such costs from the trending provisions of the State Plan.

This provision was unchanged in 1977.

G. 10 NYCRR §86-1.8(i)

Section 86-1.8(i) imposes a 7% per annum interest penalty on all overpayments made to hospitals and authorizes the Commissioner to impose further penalties on a hospital: (1) in an amount up to 25% of an overpayment made as a result of the negligent incorrect completion, or the failure to file revisions, of fiscal and statistical reports; and (2) in an amount up to 100% of an overpayment made as a result of the willful incorrect completion or the willful failure to file such reports. These penalties and charges are discriminatory and unjustified.

The penalties authorized by this section are disproportionately severe. Furthermore, although hospitals are subject to these enormous penalties for the "incorrect completion" of reports, that term is nowhere defined, nor are any of the other important terms contained in the provision. In addition, except as limited by the maximum penalties stated, the Commissioner of Health has unlimited discretion as to the amount of the penalty; he may levy the maximum or nothing at all or some intermediate amount.

As to the mandatory interest charge, although hospitals are subject to interest charges if they receive overpayments, they are not entitled to receive interest from the State if they have been underpaid. This one-way interest

obligation is clearly inequitable. Similarly, there are no penalties assessed against the State for negligent or willful underpayments.

The 1977 amendments renumbered this provision, which was formerly section 86.8(f), and added a new provision allowing the hospitals hearings prior to the imposition of these changes and penalties. They did not, however, make any changes in the mandatory interest charge or limit the Commissioner's power to impose penalties. Thus, there has been no change in this provision since 1976.

H. 10 NYCRR §86-1.21(i).

Section 86-1.21(i), another 1976 amendment which continues in effect, excludes from allowable costs those costs attributable to interest charges or penalties imposed by governmental agencies or courts, and the cost of insuring against the imposition of such penalties.

While it may have been the intent of the State to exclude from reimbursement only interest costs which are punitive in nature, section 86-1.21(i) includes no such limitation. Thus, by its terms, this provision excludes from reimbursement not only such major items as mortgage interest on government loans, which finance much of hospital construction, but also other interest charges payable to governmental

agencies which may be incurred in the normal course of business. In addition, of course, this section would disallow as a reimbursable expense the one-sided 7% interest charged to hospitals for innocent accounting errors under section 86-1.8(1). This interest payment therefore assumes the nature of a penalty, even in the absence of any finding of negligence or wrongdoing.

The 1977 amendments made no change in this provision.

I. Appeals

1. In General

The New York Public Health Law requires all reimbursement rates to be certified by the Commissioner of Health and approved by the Director of the Budget. Until these two steps are taken, a reimbursement rate is not officially in effect.

When a hospital appeals from any action affecting its reimbursement rate, whether the appeal be from the rate itself or an audit adjustment, any upward changes must also be certified by the Commissioner of Health and approved by the Director of the Budget. Thus, the same persons who issue the original rates and initiate other action with respect to rates, also determine appeals. Such a system is impermissibly biased and must be invalidated.

2. 10 NYCRR §86-1.17.

Section 86-1.17(a)(7), added by the State on the Secretary's orders, states that hospitals may appeal to the Commissioner of Health for relief from the routine and ancillary ceilings. To be successful under this section as originally enacted, a hospital "must demonstrate that its range of approved services, patient mix, lengths of appropriate stays or other pertinent factors [nowhere defined or enumerated] are direct causes for all or part of the costs in excess of said ceilings." The Commissioner can then, "in his discretion", set a new rate or deny the request. Section 86-1.17(e).

Although section 86-1.17(a)(7) is relied on as a panacea for all possible illegalities in the reimbursement methodology (277, 630, 636-639), its use as such is improper for a number of reasons.

First, it is illegal for a State Plan to leave rate-setting to a State official's "discretion", since the Medicaid Act requires rates to be set according to "methods and standards ... reviewed and approved by the Secretary [of HEW]." 42 U.S.C. §1396a(a)(13)(D). Since more than 60% of New York State's hospitals were affected by one or both of the allowable cost ceilings, the appeals process actually is the second part of the rate-setting mechanism.

As such, the vague and unregulated appeals system represents an abdication by the Secretary of his regulatory function. Cf. S. Rep. No. 1230, 92nd Cong., 2d Sess. 325 (1972).

Second, the appeals process does not function properly. The State Department of Health at one time promised to decide appeals within 90 days,* but has studiously ignored that deadline.** As a result, many appeals have lingered for several months and some for more than a year. Many hospitals have thus been required to operate at reimbursement levels which the State will ultimately determine on appeal to have been below their reasonable costs. This is particularly incongruous in light of the fact that New York State's reimbursement methodology is supposed to be a prospective one, with rates set before the rate year begins. See pp. 5-6, supra.

Third, in his "discretion", the Commissioner of Health has refused to consider appeals based on certain variables that cause differences in hospital costs, e.g., degree of unionization, intensity of care, malpractice insurance costs and disallowance of part of the costs of the salaries of interns and residents.

* Department of Health Hospital Memorandum 76-132 (December 15, 1976) at 6.

** On October 26, 1977, during the trial of the case against HEW, a senior official of that agency testified that no hospital appeal from the 1976 ceilings had yet been processed by the Department of Health, although at least 37 were pending.

The 1977 amendments deleted the phrase "lengths of appropriate stays" quoted above and added a provision allowing appeals from hospital groupings. These changes appear to be insubstantial, since appeals were ostensibly allowed based on "pertinent factors" both before and after the 1977 amendments, although that term is never defined. No other changes were made regarding appeals from the ancillary and per diem routine costs ceilings.

In sum, the appeals system, which is another of the elements of the State Plan alleged to be illegal, has not changed in substance since 1976.

J. The Out-Patient Freeze

By Chapter 76 of the Laws of 1976, continued by section 20 of Chapter 77 of the Laws of 1977, a ceiling was imposed on reimbursement for out-patient services. This ceiling was set at each hospital's 1975 out-patient reimbursement rate.

This out-patient freeze (1) results in hospitals being reimbursed at less than the cost of providing certain out-patient services which they are required by law to furnish; (2) causes the availability of out-patient services to Medicaid patients to fall below the levels available to the general population; and (3) was not approved by the Secretary as required by law.

The 1977 amendments did not affect this provision.

K. The Base Year for 1978

In addition to the continuing vitality of the above described elements of the 1976 amendments, the implementation of the amendments in the past will have a direct impact on future New York Medicaid rates. Specifically, by virtue of 10 NYCRR §§86-1.11 and 86-1.15, 1976 is the base year for setting 1978 rates. Insofar as plaintiffs' services were cut in an effort to comply with the arbitrary and unlawful 1976 amendments, the 1978 rates trended from the resulting lower costs will be below a "reasonable cost" level. Thus, a judicial determination that the 1976 amendments were unlawful will have a direct prospective effect, because such a determination will provide a basis for an adjustment in future calculations to correct the error introduced into the methodology by the improper 1976 changes.

This Appeal

As is more fully explained in plaintiffs' brief in Docket No. 77-6152, (p. 16), on August 4, 1977, the District Court vacated its judgment of August 2, 1976 insofar as it granted monetary relief against the State defendants. The ground for the vacatur was that Public Law No. 94-552, 94th Cong., 2d Sess., enacted on October 18, 1976, permitted

New York State to withdraw, retroactively to January 1, 1976, its consent to this suit, and to reassert its Eleventh Amendment immunity.

Thereafter, the State defendants moved to dismiss the complaint as to them on the ground that the case had become moot. The defendants contended that the 1977 amendments had so altered the State Plan as promulgated by the 1976 amendments that there was no longer any basis for declaratory or injunctive relief, the only relief permitted where the Eleventh Amendment is applicable. Plaintiffs argued in opposition that there was still a sound basis for declaratory and injunctive relief because (1) the 1976 amendments will continue to have a direct effect on the administration of the Medicaid program under the State Plan, (2) the 1976 amendments are the backbone of the current State Plan, and (3), in any event, the State defendants' unlawful actions are capable of repetition and, hence, fall within a recognized exception to the mootness doctrine.*

The District Court granted the motion to dismiss for the reasons set forth in the State defendants' memorandum of law (888). A judgment of dismissal was entered on October 18, 1977 (891), from which plaintiffs appeal.

* The District Court's vacatur of the August 2, 1976 judgment did not disturb its finding that the State defendants had acted "in blatant disregard" of federal requirements when they promulgated the 1976 amendments (713).

SUMMARY OF ARGUMENT

There continues to be a real, live controversy between the parties. Almost all of the essential features of the 1976 amendments to the State Plan remain unchanged and continue to affect the Medicaid reimbursement received by the plaintiffs. The 1977 amendments effected no major changes and did not alter the general ratemaking concept introduced in 1976.

Furthermore, even assuming that the 1977 amendments did have the effect claimed by the State defendants, this case falls squarely within the "capable of repetition, yet evading review" exception to the mootness doctrine. The 1977 changes were made solely at the discretion of the State defendants. Absolutely nothing assures that the few objectionable features of the 1976 amendments changed in 1977, or similar provisions, will not be reintroduced into the State Plan at some later date. The State defendants therefore cannot escape judicial review by the simple expedient of exercising their rule-making powers.

Assuming arguendo that Eleventh Amendment principles are applicable to this case, the District Court is barred only from granting retrospective compensatory relief for an accrued monetary liability. All other forms of declaratory and injunctive relief necessary to conform the State defendants' future conduct to the statutory standard remain available.

POINT I

THERE REMAINS A LIVE CONTROVERSY
BETWEEN THE PARTIES REGARDING
THE STATE PLAN WHICH SHOULD BE
ADJUDICATED BY THE DISTRICT COURT

In its order dismissing the complaint as to the State defendants, the District Court merely stated that its determination was based upon the reasons set forth in the State defendants' memorandum of law (888). Yet, despite the heavy burden they must bear to show mootness, the only "reasons" given by the State defendants are bald assertions that the 1977 amendments have somehow changed the overall result produced by the State Plan and that, accordingly, the record is too stale for an adjudication of the lawfulness of the current State Plan (793-794). It was totally inappropriate for the District Court to grant the motion to dismiss the basis of such insubstantial and conclusory allegation.

* In fact, the District Judge acknowledged at the conference of September 14, 1977, that he would grant the motion to dismiss in order to have this Court's views on the question:

"THE COURT: We will have to take it one at a time.

Gentlemen, let's talk about the mootness question first.

Nothing in the world would make me happier for this case to be moot, believe me. I have wondered some extent -- well, let me go back. I agree that the question of its status is most unusual at the very least. In fact, I think that there is possibly a serious enough question of mootness that it would not be inappropriate for the defendants to move to dismiss on the grounds of mootness, although

[Footnote continued on next page]

It must be remembered that the 1976 amendments were so significant that HEW reviewed the methodology as a new State Plan. See pp. 8-24, supra. The continuing overall strategy for reimbursement is the product of those amendments. While the 1977 amendments made certain changes in the State Plan as promulgated in 1976, if the 1976 amendments are illegal, the current New York State program falls with them.

[Footnote continued from previous page]

I don't know that I would grant such a motion, except for the purposes of having it determined by the Court of Appeals, to be perfectly frank. But the case is in a very, very odd posture. It is too bad we are all faced with this terribly puzzling situation and the last thing I would want to do would be to spend a few weeks on this trial either to conclude myself or have some appellate court conclude that I should never have acted in the first place."
(774-75)

.

"THE COURT: I think I would decide that motion in saying there are serious questions but there is enough of a proposition that could be argued in favor of mootness or at least in favor of -- well, the exercise of discretion not to take the case, that I would grant the motion to dismiss and state quite candidly I wish the Court of Appeals to review it. I mean what's the point of playing a game about it."
(783)

.

"THE COURT: I will make it clear in my opinion why I am adopting the procedure
[Footnote continued on next page]

Almost every important provision introduced in 1976 remains part of the Plan. For example, 10 NYCRR §86-1.14(b) remains part of the State Plan. By virtue of this provision, all base year routine and ancillary costs above 100% of the weighted average for a hospital's group are disallowed in computing the reimbursement rate. Aside from the blind exclusion of what may be entirely reasonable costs, this provision compels a year-to-year decrease in hospital reimbursement at a time of continually rising prices.

Although the 1977 amendments have purported to improve the manner in which hospitals are grouped in calculating these routine and ancillary cost averages, the arbitrariness of the 100% ceiling continues. As long as the grouping system is used, some hospitals will have costs above the 100% ceiling. This is the nature of an average. The only remedy in that instance is to seek an adjustment through the capricious and dilatory administrative appeals process.* Because the 100% ceilings are the keystone of the current State Plan reimbursement reduction strategy, the challenge to the Plan is not moot for this reason alone.

[Footnote continued from previous page]

I am adopting. I think I have said it quite openly on the record and you are free to quote me in the Court of Appeals. I think it is a very close, difficult question. I want to be sure it is decided. I am following the procedure for the purpose of solely seeing that is so. That doesn't necessarily mean I would decide it favorably to the plaintiffs."

(Transcript of September 14, 1977, p. 39)

* See pp. 20-23, supra.

10 NYCRR §86-1.13(c) also remains an important part of the State Plan. This provision requires that, after calculating the weighted group average per diem cost, a second average must be calculated excluding hospitals whose per diem costs exceed 125% of the weighted average or are less than 75% of the weighted average. As a practical matter, because of the pattern of hospital costs in relation to the group averages, more group ceilings are lowered than raised by this section, and those lowered are lowered by more than the raised ceilings are raised. In this way, many hospitals are arbitrarily required to conform to a level even below the actual weighted average of the group.

10 NYCRR §86-1.21(k), another dubious provision promulgated in 1976, likewise remains a critical part of the State Plan. As is more fully explained above (pp. 13-15), this regulation distorts the calculation of base year costs in a way which causes continual under-reimbursement of the hospitals.

These three provisions alone -- dealing with base year costs, routine per diem costs and ancillary costs -- are critical to the computation of Medicaid reimbursement. Together with the other 1976 amendments which remain in effect,*

* Of the twelve specific provisions under attack, the ten most significant remain exactly the same as they were when enacted in 1976, one was insubstantially changed and changes to the other, relating to audits, still leave the audit appeals process impermissibly biased. Supra, p. 20.

these provisions embody the substance of the State Plan being administered today. Moreover, insofar as these provisions unlawfully coerced the hospitals to reduce services in 1976, there will be a further direct impact on reimbursement in 1978 and subsequent years. That is so because, pursuant to 10 NYCRR §§86-1.11 and 86-1.15, 1976 serves as the base year for computing 1978 reimbursement rates. 1976 also affects the 1979 rates by operation of section 86-1.21(k).

The irrationality of the 1976 amendments is, in addition, exacerbated by the administrative appeals process. The appeals process remains a cumbersome system which results in unreasonable delays in reimbursement adjustments. Furthermore, the appeals process is still impermissibly biased, because, by virtue of the 1976 amendments, the State officials who certify the original rates must also approve any changes granted on appeal.*

As the basis for their motion to dismiss the State defendants argued that the effect of the 1976 amendments was no longer of consequence, because the 1977 amendments were "so substantial" that they significantly altered the "overall result produced by the state's reimbursement methodology"

* It should be remembered that the out-patient freeze (see p. 23 *supra*), extended by section 20 of Chapter 77 of the Laws of 1977, is also under challenge by plaintiffs. That aspect of the State's Medicaid program, which is separate and distinct from the amendments under discussion, presents another real and substantial controversy between the parties.

(801). Yet, although they acknowledged that the record before the District Court was "of no help" regarding the "significance of the 1977 changes..." (803), the State defendants offered no proof as to the precise effect on the State Plan of the 1977 amendments. The motion to dismiss was thus predicated on bald, conclusory allegations that the 1977 changes had vitiated the 1976 amendments and had made the record stale. This Court's recent decision in Kaye v. Funding Systems Corp., Docket No. 76-7272 (2d Cir. June 20, 1977), demonstrates, however, that such unsupported assertions were a wholly inadequate basis for dismissal on the ground of mootness.

The plaintiff in that case was a stockholder of defendant Funding Systems Corp. (FSC) who was challenging the acquisition of a controlling interest in FSC by another company, also named as a defendant. During the course of the litigation the acquiring company sold its entire interest in FSC to two individuals. The defendants then moved to dismiss on the ground that the sale of stock to the individuals had mooted plaintiff's claims. The plaintiff contended that the sale was a sham and that the acquiring company still retained actual control of FSC.

The District Court accepted the defendants' view of the matter and granted the motions to dismiss. In reversing,

this Court specifically addressed itself to "the standard of proof required where matters outside the pleadings form the basis for a pre-trial dismissal on grounds of mootness." Id. at slip op. p. 4259. It was held that:

"[W]here mootness not established by the pleadings is the basis for pre-trial dismissal of an action, the governing standard is akin to that established by Rule 56 of the Federal Rules of Civil Procedure; namely, such dismissal, like summary judgment, is appropriate only where the opposing papers of the parties leave no genuine issue for in-court resolution."

Id. at slip op. p. 4260
(emphasis added).

The naked allegations of the State defendants clearly did not satisfy this standard of proof. There is absolutely nothing in the record to support the contention that the 1977 amendments affected the "overall result" produced by the State Plan as promulgated in 1976, let alone demonstrate no genuine issue of fact on the question. Thus, for this reason alone, the motion to dismiss was improperly granted.

Furthermore, even if the State defendants had established that the 1977 changes had some important impact on the State Plan, more was required to warrant dismissal on the ground of mootness. A challenge to a statutory or regulatory scheme is not mooted merely because there are changes or amendments during the course of litigation.

In National Association of Greeting Card Publishers v. United States Postal Service, No. 75-1856 (D.C. Cir. December 28, 1976), for example, there were challenges to a series of temporary and permanent postal rate increases, including a rate increase that had been superseded many months before the Court of Appeals reached its decision. In its per curiam opinion, the Court sua sponte raised the question of whether that aspect of the appeal had been mooted. The Court's reasoning in deciding that the issue was not moot is particularly apposite to the case at bar:

"Although implementation of the new permanent rates may preclude this Court from presently providing an effective remedy for any injury as the result of the prior, allegedly unlawful permanent rates, ... the appeal need not be dismissed as moot. Petitioner has a continuing interest in the establishment of postal rates that comply with the Act, and it appears from the record ... that the new permanent rates are based on a methodology significantly similar to that which petitioner here challenges as violative of the Act."

Id. at slip op. p. 13n.21.

Similarly, in National Foundation v. City of Fort Worth, 415 F.2d 41 (5th Cir. 1969), cert. denied, 396 U.S. 1040 (1970), the local law under challenge had been substantially amended before the appeal reached the Court of Appeals. The statute had not been repealed in toto, however, and many of the provisions originally attacked by the plaintiff continued in

effect. Id. at 45. In denying a motion to dismiss the appeal as moot, the Court held, inter alia, that there continued to be a "real and substantial" controversy because of the persistence of certain provisions of the original law. Id.

Natural Resources Defense Council, Inc. v. E.P.A., 489 F.2d 390 (5th Cir. 1974), reversed on other grounds, 421 U.S. 60 (1975), concerned an attack on a certain strategy incorporated into a State's clean air plan. Specifically, the State proposed to meet federal ambient air standards for particular pollutants by atmospheric dispersal. Id. at 403. The plan would have required taller smokestacks to enhance dispersal effects. Id.

Prior to oral argument of the appeal the State abandoned the tall smokestacks concept. Id. at 404. The Court rejected the contention that the State's change mooted the appeal, however, because the "general idea" of pollution control through dispersal remained in the plan. Id. at 405.

Applying the reasoning of these decisions to the case at bar, it is clear that there would be a live controversy to be adjudicated below, even if the State defendants demonstrated that the 1977 amendments had some important effect on the result produced by the State Plan. In large part, the present methodology of the State Plan is embodied in the 1976 amendments that remain in effect. Plaintiffs are

challenging the same general ratemaking concepts -- such as the 100% ceiling -- introduced in 1976 and unchanged in 1977. And plaintiffs clearly have a continuing interest in the establishment of Medicaid rates that comply with the Medicaid Act.

In the event the District Court, on remand, finds some or all of these provisions violative of the law, there is ample relief which can be granted to the plaintiffs (see Point III). The District Court can, of course, enter a declaratory judgment. Moreover, the State defendants can be enjoined from further implementation of the objectionable provisions and directed to develop substitute procedures consistent with the Court's ruling or to return to the procedures that preceded the 1976 amendments. Finally, the District Court can direct the State defendants to adjust future reimbursement methodologies to allow hospitals to restore services and programs which they have been coerced into deleting by the illegal regulations.

POINT II

THE STATE DEFENDANTS' ACTIONS ARE CAPABLE OF REPETITION AND, HENCE, APPROPRIATE FOR ADJUDICATION WHATEVER THE EFFECT OF THE 1977 AMENDMENTS

Even if the 1977 amendments have altered the State Plan to the extent contended by the State defendants, that change has occurred solely through the exercise of defendants' discretion. Absolutely nothing prevents a subsequent repeal of those amendments or future changes in the State Plan which would reintroduce any or all of the objectionable features of the 1976 amendments, since HEW has already acquiesced in them.

It is, of course, well-established that a voluntary change in conduct by a defendant does not moot a challenge to his prior practices. E.g., DeFunis v. Odegaard, 416 U.S. 312, 318 (1974). A defendant will not be permitted to use mootness in such situations to escape judicial review, while retaining the power to resume the challenged conduct at some later date. E.g., Roe v. Wade, 410 U.S. 113, 125 (1973). Accordingly, as long as there is the possibility of a repetition of the challenged conduct, there remains a live controversy for adjudication. E.g., Local 74 v. N.L.R.B., 341 U.S. 707, 715 (1951); Browning Debenture Holders' Committee v. DASA Corp., 524 F.2d 811, 816 (2d Cir. 1975). Indeed, "to grant dismissal for mootness, the court must be fully satisfied that 'the allegedly wrongful behavior' claimed to have been discontinued by

the defendant 'could not reasonably be expected to recur.'" Kaye v. Funding Systems Corp., Docket No. 76-7272, slip op. p. 4261 (2d Cir. June 20, 1977) (citations omitted).

Thus, in National Association of Greeting Card Publishers v. United States Postal Service, No. 75-1856 (D.C. Cir. December 28, 1976), discussed in Point I, an alternate ground for the Court's determination that the case was not moot was the possibility of a repetition of the challenged conduct by the Postal Service. "[T]here is nothing to indicate that this cycle [of rate changes] will not be repeated to the possible frustration of future petitions to review." Id. at slip op. p. 14n.21.

Likewise in National Foundation v. City of Fort Worth, 415 F.2d 41 (5th Cir. 1969), cert. denied, 396 U.S. 1040 (1970), also discussed in Point I, the possibility of repetition of the defendants' conduct was an alternate ground for denying the motion to dismiss the appeal as moot. The Court observed that the amendments to the challenged law "can be repealed, and what has been amended can be reenacted." Id. at 45 (citation omitted).

Big Rivers Electric Corp. v. E.P.A., 523 F.2d 16 (6th Cir. 1975), cert. denied, 425 U.S. 934 (1976), and United Air Lines, Inc. v. C.A.B., 518 F.2d 256 (7th Cir. 1975), are also directly on point. In Big Rivers, the challenged State regulation had been repealed prior to argument of the appeal. The Court nevertheless denied motions to dismiss the appeal

because the case concerned administrative action "capable of repetition, but which would evade review if the principle of mootness were strictly applied." 523 F.2d at 19.

United Airlines involved a challenge to a C.A.B. order which had been revoked by the time the appeal was perfected. Then Judge Stevens, sitting as motion judge, nevertheless denied the C.A.B.'s motion to dismiss the appeal as moot under the "capable of repetition, yet evading review" exception. 518 F.2d at 258. In so doing, Judge Stevens said that an administrative agency could not escape judicial review by the "simple expedient" of repealing the challenged order. Id. The full panel of the Court of Appeals thereafter confirmed Judge Stevens' decision. Id. at 259.

Golden Holiday Tours v. C.A.B., 531 F.2d 624 (D.C. Cir. 1976), is also analogous. The petitioner there was a tour operator which had suffered a substantial financial loss as a result of the C.A.B.'s refusal to accept the filing of an amendment to a tour prospectus due to an alleged violation of C.A.B. regulations. Since the subject acts of the controversy were all in the past, the Court raised the question of whether the case was moot. Id. at 626. The Court noted that it could do nothing to "provide any effective remedy for the particular injuries alleged." Id. The remedy sought was simply "in the nature of a declaration that the action taken was wrongful, in hopes that that will deter similar acts in the future." Id.

The Court ruled, however, that the case was not moot under the "capable of repetition, yet evading review" principle. Id. The Court found that it was not "implausible" that the petitioner, which frequently had occasion to amend its tour prospectus, would again run afoul of C.A.B. regulations. Since the time available for challenging the C.A.B. rulings was short, there would never be an opportunity for judicial review, unless the mootness exception were invoked. Id.

This is precisely the situation at bar. In urging dismissal below the State defendants, who previously acted in "blatant disregard" of federal law (713), gave no assurances that the past illegalities would not be repeated. Rather, the sole ground for their motion to dismiss was that they had sufficiently tampered with the State Plan to make the record stale. Plainly, such allegations are wholly inadequate to establish the requisite "firm ... factual footing" that a recurrence of the proscribed conduct is not likely. Kaye v. Funding Systems Corp., Docket No. 76-7272, slip. op. p. 4261 (2d Cir. June 20, 1977). The State defendants have thus utterly failed to meet their "heavy burden" of demonstrating "that 'there is no reasonable expectation that the wrong will be repeated.'" United States v. W.T. Grant Co., 345 U.S. 629, 633 (1953) (emphasis added); accord, Kaye v. Funding Systems Corp., supra.

On this record, then, the possibility of repetition of conduct evading review is evident. It is not at all "implausible"

that these defendants will again run afoul of the Medicaid Act. Yet future challenge to their activities could be similarly frustrated by the "simple expedient" of further amendments in the midst of litigation. The dismissal, if left standing, would thus allow the State defendants complete freedom to repeat the same or similar violations of law, while remaining immune from judicial scrutiny. Accordingly, even assuming that the 1977 amendments have the effect asserted by the State defendants, this case is still justiciable under the "capable of repetition, yet evading review" exception to the mootness doctrine.

POINT III

THE ELEVENTH AMENDMENT ONLY BARS THE AWARD OF COMPENSATORY PAYMENTS FOR ACCRUED MONETARY LIABILITY

As demonstrated above, even if the District Court's partial vacatur of the August 2, 1976 judgment was sound, there remains a real and substantial controversy between the parties. Under such circumstances the federal courts still retain broad power to adjudicate the rights of the parties and to grant appropriate relief. Indeed, it is evident from the authorities that, consistent with its express language, the Eleventh Amendment immunity has been given the narrowest possible scope regarding its effect on federal judicial power.

Thus, in Edelman v. Jordan, 415 U.S. 651 (1974), it was held that the Eleventh Amendment only proscribed the award of compensatory - as distinguished from remedial - relief. Edelman was a class action which challenged the manner in which State officials administered a federal - State disability benefits program. The plaintiff charged that in the processing of applications for benefits the State officials were violating applicable federal regulations. Id. at 655-56. Declaratory and injunctive relief was demanded by the complaint, including an "injunction" directing the State officials to award to the class disability benefits wrongfully withheld. Id. at 656.

The District Court granted the relief demanded. That judgment was affirmed by the Court of Appeals. The Supreme Court reversed, however, insofar as the judgment directed the payment of withheld benefits.

In reaching its decision, the Court held that the Eleventh Amendment prohibits the granting of relief "measured in terms of a monetary loss resulting from a past breach of a legal duty on the part of the defendant state officials." Id. at 668. A federal court may not order payments in compensation for any "accrued monetary liability" (id. at 665) that might result from the acts of State officials.

But that is all that Edelman prohibits. A federal court remains free to grant all remedial relief required to conform the future conduct of State officials to the applicable law. Thus, a District Court may grant prospective declaratory and injunctive relief against State officials, notwithstanding that compliance will entail the expenditure of State funds. Id. at 668.

To reiterate, Edelman only proscribed "'the award of an accrued monetary liability ...' which represented 'retroactive payments'" Milliken v. Bradley, 97 S.Ct. 2749, 2761-62 (1977) (emphasis in original) (quoting from Edelman v. Jordan,

supra, at 663-64). The Court in Milliken felt that the fact that there was no "raid on the state treasury for an accrued monetary liability" was enough to distinguish Edelman. Milliken, 97 S. Ct. at 2762 n.22.

The rationale for this construction of the Eleventh Amendment is evident. There is no interference with the sovereign prerogatives of a State when State officials, administering a federally-funded program, are merely required to conform their future conduct to a particular standard. Under such circumstances the State is free to determine in advance whether and to what extent it wishes to engage in the activity which generates the obligations imposed by the Court. The assumption of the obligations is thus voluntary on the part of the State. Any ancillary impact upon the State treasury is solely by choice.

Conversely, imposing compensatory damages for past conduct denies the State any choice or opportunity to plan for increased expenditures. In performing governmental functions, a State would risk penalty if a subsequent adjudication were to determine that there was some violation of law. The direct interference with the planning of governmental operations posed by such a possible penalty is obvious, since a State could never be certain it was acting in conformity with as yet unadjudi-

cated standards.*

Moreover, insofar as State resources are limited, a judgment requiring the payment of compensatory damages would necessarily reduce the funds available for the provision of future services. See Edelman, supra, at 666 n.11. Hence, the Eleventh Amendment proscription operates against compensatory damages for accrued monetary liability.

In their motion to dismiss, the State defendants acknowledged generally that the Eleventh Amendment does not bar prospective relief designed to assure that the future conduct of State officials is in conformity with the law. But the State defendants contended that there are strict limitations on the type of prospective relief that can be granted.

Thus, the argument was advanced below that no prospective declaratory or injunctive relief can be granted "which has either the purpose or direct or indirect effect of establishing rights or liabilities with respect to any period preceding entry of the order" (799). In support of their position, the State defendants cited Edelman, supra,

* Once the standard is judicially determined, however, a State may not use its immunity to avoid compliance with the court order. Thus, State noncompliance may be sanctioned with fines and penalties, even though there is an impact on the State treasury. E.g., Class v. Norton, 505 F.2d 123 (2d Cir. 1974); Rodriguez v. Swank, 496 F.2d 1110 (7th Cir.) cert. denied, 419 U.S. 885 (1974).

Rothstein v. Wyman, 467 F.2d 226 (2d Cir. 1972), cert. denied, 411 U.S. 921, rehearing denied, 411 U.S. 988 (1973), and Jordan v. Trainor, 551 F.2d 152 (7th Cir. 1977), rehearing en banc granted (April 25, 1977).

The thrust of this argument is not entirely clear. Apparently, it is the State defendants' position that prospective relief cannot be granted if it would be predicated upon an adjudication of the lawfulness of prior conduct. If that is their argument, it is absurd. The Eleventh Amendment bars the granting of a certain type of relief; it does not preclude the consideration of past practices as grounds for otherwise permissible relief. Virtually all adjudications by a court of law are based upon facts that occur or exist prior to the lawsuit; defendants' argument requires this Court to hold, in effect, that there is no federal jurisdiction over State officers at all.

The very authorities relied upon by the State defendants belie such a reading of the Eleventh Amendment. In Edelman, the Court left untouched that portion of the District Court's judgment which declared prior State practices invalid and directed future compliance with the applicable federal regulations. Likewise, in Rothstein (which was cited with approval in Edelman), this Court upheld the injunctive relief granted by the District Court, which was designed "to terminate a practice ... found to be in conflict with federal statutory

law" Rothstein, supra, 467 F.2d at 236 (emphasis added). Jordan v. Trainor says only that the Eleventh Amendment bars "[t]he granting of any type of relief constituting entitlement to retroactive benefits claimed against the state ..." (551 F.2d at 155) (emphasis added), which we have acknowledged. And in Milliken v. Bradley, the approved prospective relief was based on a record of an "antecedent violation." Id., 97 S.Ct. at 2762.

Plainly, then, these cases do not stand for the proposition advanced by the State defendants. Obviously a court must adjudicate the lawfulness of past practices, if there is to be a basis for prospective injunctive relief. As long as the relief fashioned does not require compensatory payments, Eleventh Amendment principles are satisfied.

Nor is there any merit to the State defendants' contention that Eleventh Amendment considerations bar prospective declaratory and injunctive relief where the direct or indirect purpose would be to establish entitlement to compensatory relief in State courts or any other forum (799). The "purpose" of a judgment is irrelevant to any question of jurisdiction. Furthermore, this argument, if accepted, would effectively destroy all federal jurisdiction over State defendants, since virtually any judgment invalidating State laws or State official conduct might be used later by persons injured by the invalidated action in a lawsuit for damages in State court. The primary authority upon which the

State defendants rely for this argument, Jordan v. Trainor, simply does not support their position.

Jordan v. Trainor is the Edelman case on remand. Having been directed by the Supreme Court to vacate the compensatory damages portion of its judgment, the District Court instead ordered the State defendants to notify each class member that (1) there had been a denial of benefits, (2) the class member was entitled to a specified amount of benefits, (3) an appeal challenging the denial could be filed, and (4) an enclosed appeal form could be filed by the class member with the State to perfect his claim for denied benefits. Jordan v. Trainor, supra, 551 F.2d at 154.

In reversing the District Court on Eleventh Amendment grounds, the Court of Appeals observed that the admission of liability required to be included in the notice "would automatically result in payment of state funds". Id. The Court thus logically concluded that the District Court had accomplished by indirection what had already been prohibited by the Supreme Court in Edelman, namely, a judgment for compensatory damages. Jordan v. Trainor, supra, 551 F.2d at 156.*

* The other cases relied upon by the State defendants in support of this argument are totally inapposite and warrant only brief discussion. In Public Service Commission v. Wycoff Co., Inc., 344 U.S. 237 (1952), relief was denied because there was no "case or controversy." Local No. 2 v. Paramount Plastering, Inc., 310 F.2d 179 (9th Cir. 1962), denied relief as to a question of State law solely within the province of the State to decide.

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But nothing in Jordan v. Trainor bars the granting of relief simply because that relief could be used in another forum to recover such damages. And, indeed, in Edelman itself, the Court let stand the District Court's finding that State officials had acted unlawfully, without regard to the possible collateral effect in State court.*

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In Shank v. N.L.R.B., 260 F.2d 444 (7th Cir. 1958), the declaratory relief sought was, in effect, a judicial review of the actions of a State court in a prior pending action. General Electric Co. v. Local 761, 395 F.2d 891 (6th Cir. 1960), involved a dispute over a contract which had expired prior to the decision, thus mooted the case. Finally, Ove Gustavsson Contracting Co. v. Floete, 278 F.2d 912 (2d Cir. 1960), denied declaratory relief because, in reality, the suit was for breach of contract against the United States. Only the Court of Claims had subject matter jurisdiction.

None of the above cases, moreover, involved an Eleventh Amendment issue.

- * The Eleventh Amendment is directed only at relief granted by the federal courts constituting judgments for money damages or judgments "in practical effect indistinguishable... from an award of damages against the State." Jordan v. Trainor, 551 F.2d at 156 (quoting Edelman v. Jordan, 415 U.S. at 668). Clearly no Eleventh Amendment principles are violated by a federal declaratory judgment merely because monetary relief might be obtained thereafter in State courts. The State's decision to subject itself to such suits would be a sovereign decision made independently of any coercive federal judicial order. That freedom of choice by the State is what the Eleventh Amendment is designed to protect.

Likewise, the possibility of subsequent HEW administrative relief through compliance proceedings, which could result from a declaration of rights, does not preclude federal judicial relief. It is well-established that the Eleventh Amendment does not apply to federal-State relations and that the National Government may attach conditions to

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Lewis v. Shulimson, 534 F.2d 794 (8th Cir. 1976),
cert. denied sub nom. Gourley v. Lewis, 97 S.Ct. 1570, re-
hearing denied, 97 S.Ct. 2643 (1977), moreover, indicates
that no Eleventh Amendment issue is raised by the possibility
that the federal relief may be used in another forum against
the State officials. There the Court of Appeals upheld a
District Court order directing the defendant State officials
to notify all class members who had been unlawfully denied
medical assistance. There was clearly the prospect that such
notifications would lead to State court claims. The Court
was nevertheless satisfied that there was no Eleventh Amend-
ment problem as long as there was no federal order requiring
retroactive payments.

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the grant of federal moneys. See, e.g., Oklahoma v. Civil Service Commission, 330 U.S. 127, 143 (1947); Steward Machine Co. v. Davis, 301 U.S. 548, 586-96 (1937). The States, of course, are always free to reject the federal grant and avoid compliance with federally-prescribed conditions. Id. See also, Alabama Nursing Home Ass'n. v. Califano, 433 F. Supp. 1325, 1330 (M.D. Ala. 1977) ("State participation in Social Security Act programs is voluntary, and the state may withdraw if it wishes. But as long as it remains in a program and accepts federal funds, it must follow the federal statutes.").

Thus, the possibility of State court or federal administrative monetary relief based upon a declaratory judgment issued by the District Court raises no Eleventh Amendment problem. In either instance, there would be an impact on the State treasury only if the State, in the exercise of its sovereign will, chooses to be subject to such claims. Obviously, no Eleventh Amendment problem is presented by that prospect, since the State's liability would not result from an application of federal judicial power.

The final argument presented by the State defendants below was that prospective declaratory or injunctive relief cannot be rendered solely to give an advisory opinion (799). We agree that the District Court's Article III jurisdiction still requires a "case or controversy", which, as we have demonstrated above in Points I and II exists in the case at bar.

CONCLUSION

The judgment of dismissal should be reversed and the case remanded to the District Court for a trial on the merits.

Dated: New York, New York
November 14, 1977.

Respectfully submitted,

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COUNTY OF NEW YORK)

George M. Gundlach being duly sworn, deposes and states:

I am not a party to the action, am over 18 years of age and reside at W. End Ave. N.Y., N.Y.

On November 14, 1977 , I served the attached Brief upon the following attorney(s) at the address designated by ~~MAN~~ (them) for that purpose:

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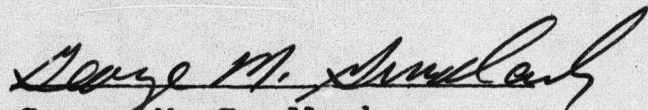
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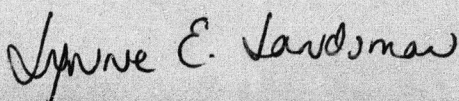
Said service was made by depositing 2 true copies of the attached

Brief enclosed in a postpaid properly addressed wrapper in an official depository under the exclusive care and custody of the United States Post Office Department within the State of New York.


George M. Gundlach

Sworn to before me this

14th day of November 1977.



LYNNE E. LANDSMAN
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Qualified in New York County
Commission Expires March 30, 1979